

OHC Request for Patient Medical Records



START HERE.

Referring Physician: _____

Fax Number: _____

Office Number: _____

Patient's Name: _____

Date of Birth: _____

Diagnosis: _____

Primary Care Physician: _____

Patient Scheduled with OHC Physician: _____

Date and Location to be Seen: _____

We Need the Following Records:

HEAD AND NECK

<input type="checkbox"/> CAT Scan/Other Scans	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> X-rays	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Pathology	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Consult/Office Visit Notes	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Labs (CBC, Chemistry Panel)	<input type="checkbox"/> Received by OHC

ESOPHAGEAL

<input type="checkbox"/> EGD Report	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Esophageal Ultrasound	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Pathology	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Operative Notes & Additional Pathology	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> CAT Scan/Other Scans	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> X-rays (CXR)	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Consult/Office Visit Notes	<input type="checkbox"/> Received by OHC

LIVER

<input type="checkbox"/> CAT Scan/Other Scans	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> CT Guided Biopsy Report	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Pathology	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Consult/Office Visit Notes	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Labs (AFP, Hepatitis Panel, CBC, Chemistry Panel)	<input type="checkbox"/> Received by OHC

PANCREATIC

<input type="checkbox"/> CAT Scan/Other Scans	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Endoscopic Ultrasound Report	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> CT Guided Biopsy Report	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Pathology	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Operative Note	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Consult/Office Visit Notes	<input type="checkbox"/> Received by OHC
<input type="checkbox"/> Labs (CA 19-9, CBC, Chemistry Panel)	<input type="checkbox"/> Received by OHC

OTHER OR PENDING RESULTS

Fax Documents to 513-762-2483 by This Date:

OHC Team Member Requesting Records:

*Thank you for choosing OHC. If you have any questions, please contact Medical Records at 1-888-649-4800 and press 5.
5053 Wooster Road, Cincinnati, Ohio 45226*

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